

Rooted Oak

THERAPY & COACHING | Understanding Your Story. Growing Forward.

Authorization to Coordinate Care

Between Jeffrey Kukral, LMFT 154425, and one named therapist

CLIENT AND OTHER THERAPIST

Client name

Date of birth

Other therapist name and credentials

Phone

Practice / organization

Secure fax or contact information

PERMISSION AND SCOPE

I authorize Jeffrey Kukral, LMFT 154425, of Rooted Oak Therapy & Coaching and the therapist named above to communicate with each other in both directions solely to coordinate my mental health care.

They may discuss my participation in treatment, presenting concerns, diagnoses, treatment goals, progress, relevant risk or safety concerns, and care recommendations as needed for that purpose. This authorization covers verbal communication and brief written care-coordination summaries. It does not authorize release of my entire record.

This form does not authorize disclosure of separately maintained psychotherapy notes, substance use disorder counseling notes, or records subject to additional legal protections that require separate consent.

DURATION AND MY RIGHTS

This authorization expires one year after I sign it, unless I write an earlier expiration date below. I may revoke it at any time by giving written notice to Jeffrey Kukral, LMFT, at the address below. Revocation does not undo information already disclosed in reliance on this authorization.

Earlier expiration date, if desired

Signing is voluntary. My treatment, payment, enrollment, and eligibility for benefits will not be conditioned on signing this form. Information disclosed to the other therapist may be redisclosed and may no longer be protected by HIPAA, although other confidentiality laws may apply. I may request a copy of this signed authorization.

SIGNATURE

Client or authorized representative signature

Date

If signing for the client, relationship / authority